OMB Approved No. 2900-0068
Respondent Burden: 40 minutes

Department of Veterans Affairs

APPLICATION FOR SERVICE-DISABLED VETERANS

IMPORTANT INFORMATION

Eligibility
S-DVI provides up to $10,000 of life insurance for eligible veterans. To be eligible for S-DVI, you must meet **all three** of the following requirements:

1. you were released from active service in the Armed Forces on or after April 25, 1951, under other than dishonorable conditions.

2. **it has been less than 2 years since VA notified you of a new service-connected disability or you are currently waiting for a rating for your service-connected disability. Please Note**: The disability you are rated for must be a **new** disability, not an increase in a disability you already have. Being increased to 100% or being granted individual unemployability **does not** automatically entitle you to a new eligibility period.

3. you are in good health **except for your service-connected disability.** We will evaluate all health conditions that are not service-connected. Information about any health conditions should be included on your application.

Cost Before you apply for S-DVI coverage, we encourage you to compare our premium rates to commercial insurance companies. If your disability is not serious, you may be able to find better rates from a commercial company.

When considering the cost of S-DVI coverage, remember that if **you are or become totally disabled and unable to work for six or more months you do not have to pay premiums** on your Government Life Insurance policy. Most commercial life insurance companies add an additional charge for this benefit.

Speeding Up the Application Process We can process your application more quickly if you send us a copy of the letter from VA that first notified that your disability was rated service-connected within the last two years.

Mailing Address If you meet these criteria, please complete and sign the application and then send immediately to:
Department of Veterans Affairs Regional Office and Insurance Center (RH), P.O. Box 7208, Philadelphia, PA 19101.

Questions If you have questions about Government Life Insurance, you can call us toll-free at **1-800-669-8477** or visit our website at: **www.insurance.va.gov.**

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS APPLICATION

1. Name and Mailing Address for Insurance Purposes

A. First, Middle, Last Name	B. Mailing Address

2. Beneficiary Designation and Selection of Settlement Option - The preprinted phrase "Or to survivors" means that a share of a beneficiary(ies) who dies before you will be paid to the surviving beneficiaries. For example, if you name three principal beneficiaries and one dies before you, the share will be paid to the remaining two principal beneficiaries.

Complete Name and Address of Each Principal and Contingent Beneficiary (For married women, enter her own first and middle names. For example, Mary Rose Smith, not Mrs. John Smith)	Beneficiary's Social Security Number (If known. This is not required for this designation to be valid)	Relationship of the beneficiary to you	Share to be paid to each beneficiary (Use $ amounts, %, or fractions)	Payment Option for Each Beneficiary (See pamphlet for more information)
				Lump Sum
				Lump Sum
				Lump Sum
Or to survivors				Lump Sum
Contingent (Person(s) who get the proceeds if the principal beneficiary(ies) die before the insured. If none, write "NONE"				
				Lump Sum
				Lump Sum
				Lump Sum
Or to survivors				Lump Sum

EVERY QUESTION MUST BE ANSWERED, BE SURE TO SIGN ON THIS SIDE

3. VA Claim Number *(If any)*	4. Social Security Number	5. Date of Birth *(Month, Day,Year)*	6. Daytime Telephone Number *(Include Area Code)* ( )	7. Email address

8. Enter the amount, plan, and premium of the insurance for which you are applying. (See Pamphlet 29-9 - Service-Disabled Veterans Insurance Information and Premium Rates)

A. Amount of Insurance	B. Plan of Insurance	C. Monthly Premium

9. Check the method showing how you wish to pay for this insurance

☐ A. I want to pay premiums by a monthly deduction from my VA Compensation or Pension. (We will start the deduction for you if the insurance is approved)

☐ B. I want to pay premiums by a monthly allotment from my military service/retirement pay. (We will start the allotment for you if the insurance is approved)

☐ C. I want VA to automatically withdraw the premium each month from my bank account (VA MATIC) (Send your first payment with this application)

☐ D. I will send premiums directly to VA as follows: (Send your first payment with this application)

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

10A. Are you now working? ☐ Yes ☐ No	10B. Do you work full-time? ☐ Yes ☐ No	10C. If you are not working or working part-time, explain why

11A. Are you now hospitalized? (*If "YES", for what condition(s)? (List below)* ☐ Yes ☐ No	11B. Name and Address of Hospital

12. Have you ever been treated for the use of alcohol or drugs, including marijuana, sedatives, stimulants, etc.? *(If "YES", give date(s) and type of treatment(s)* ☐ Yes ☐ No

13. Have you had any of the following:	YES	NO
A. Lung condition?		
B. Mental or nervous disorders?		
C. Blood disorder?		
D. Heart condition?		
E. High blood pressure?		
F. Paralysis?		
G. Cancer or tumor?		
H. Stomach condition?		
I. Diabetes?		
J. Seizure disorder?		

14. If your answer to any part of Item 13 is "YES", give dates, duration and other details *(If more space is needed, attach separate sheet)*

15. Have you had any other physical defect or disease? *(If "YES", explain below)* ☐ Yes ☐ No

16A. Height Feet Inches

16B. Weight Lbs.

16C. Has your weight changed more than 10 pounds during the past two years? *(If "YES", give complete details including amount gained or lost and length of time present weight maintained)* ☐ Yes ☐ No

CERTIFICATION: I have reviewed all of my answers above and certify that they are true and correct to the best of my knowledge and belief.

17A. Signature of Applicant (*Do NOT print, sign in ink)*	17B. Date

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, published in the Federal Register. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information to determine, establish or verify your eligibility for VA Insurance benefits (38 U.S.C. 722). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet page at www.whitehouse.gov/library/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.